		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039347

Facility Name: Montgomery Nursing and Rehabilitation Center

Address: South Route 127, P.O. Box 309 (Number) Hillsboro (City) 62049 (Zip Code)

County: Montgomery

Telephone Number: (217) 532-6126 **Fax #** (217) 532-9465

IDPA ID Number: 37-1323740

Date of Initial License for Current Owners: 04/01/1994

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: J. Terry Dooling **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) J. Terry Dooling
(Title) Treasurer

Paid Preparer

(Signed) See Accountants' Compilation Report (Date)
(Print Name and Title) J. Terry Dooling, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C., 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	21	Skilled (SNF)	21	7,686	1
2		Skilled Pediatric (SNF/PED)			2
3	80	Intermediate (ICF)	80	29,280	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	101	TOTALS	101	36,966	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,436	2,121	2,985	8,542	8
9	SNF/PED					9
10	ICF	13,082	8,074		21,156	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,518	10,195	2,985	29,698	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.34%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/1994

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/1994 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 2,985

Medicare Intermediary Trispan Health Services

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Cen # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	160,298	10,524	5,595	176,417		176,417		176,417			1
2	Food Purchase		147,959		147,959		147,959	(36)	147,923			2
3	Housekeeping	82,638	9,981		92,619		92,619		92,619			3
4	Laundry	55,332	11,715		67,047		67,047		67,047			4
5	Heat and Other Utilities			85,965	85,965		85,965	389	86,354			5
6	Maintenance	43,785	6,087	31,771	81,643	410	82,053	432	82,485			6
7	Other (specify):* Waste Removal			5,382	5,382		5,382		5,382			7
8	**TOTAL General Services**	342,053	186,266	128,713	657,032	410	657,442	785	658,227			8
	B. Health Care and Programs											
9	Medical Director			9,600	9,600		9,600		9,600			9
10	Nursing and Medical Records	1,000,966	62,032	19,638	1,082,636	(5,036)	1,077,600	(1,895)	1,075,705			10
10a	Therapy		949	210,153	211,102		211,102	2,617	213,719			10a
11	Activities	45,806	4,455	559	50,820		50,820		50,820			11
12	Social Services	28,255	197	726	29,178		29,178		29,178			12
13	Nurse Aide Training					7,652	7,652	(600)	7,052			13
14	Program Transportation		3,120		3,120		3,120		3,120			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,075,027	70,753	240,676	1,386,456	2,616	1,389,072	122	1,389,194			16
	C. General Administration											
17	Administrative	58,975	3,795	164,999	227,769	(760)	227,009	(64,786)	162,223			17
18	Directors Fees											18
19	Professional Services			40,991	40,991		40,991	(33,096)	7,895			19
20	Dues, Fees, Subscriptions & Promotions			49,563	49,563	(2,109)	47,454	(26,470)	20,984			20
21	Clerical & General Office Expenses	57,404	14,509	43,407	115,320		115,320	11,797	127,117			21
22	Employee Benefits & Payroll Taxes			228,464	228,464	148	228,612	9,378	237,990			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,067	7,067	(305)	6,762	6,587	13,349			24
25	Other Admin. Staff Transportation							4,551	4,551			25
26	Insurance-Prop.Liab.Malpractice			47,172	47,172		47,172	850	48,022			26
27	Other (specify):*											27
28	**TOTAL General Administration**	116,379	18,304	581,663	716,346	(3,026)	713,320	(91,189)	622,131			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,533,459	275,323	951,052	2,759,834		2,759,834	(90,282)	2,669,552			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center #0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			105,174	105,174		105,174	2,715	107,889			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			215,403	215,403		215,403	(22,684)	192,719			32
33	Real Estate Taxes			37,207	37,207		37,207	443	37,650			33
34	Rent-Facility & Grounds							2,962	2,962			34
35	Rent-Equipment & Vehicles			2,176	2,176		2,176	603	2,779			35
36	Other (specify):* **Mortgage Ins.**			11,711	11,711		11,711		11,711			36
37	**TOTAL Ownership**			371,671	371,671		371,671	(15,961)	355,710			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			327	327		327		327			38
39	Ancillary Service Centers		72,088	7,081	79,169		79,169		79,169			39
40	Barber and Beauty Shops		990		990		990		990			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			55,450	55,450		55,450		55,450			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		73,078	62,858	135,936		135,936		135,936			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,533,459	348,401	1,385,581	3,267,441		3,267,441	(106,243)	3,161,198			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(36)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(275)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,600)	20		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(2,306)	24		19
20	Contributions	(129)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(23,092)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(4,513)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (31,951)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(74,292)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (74,292)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (106,243)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Montgomery Nursing and Rehabilitation Center

ID# 0039347

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Eliminate PAC & Lobbying Dues	$ (2,218)	20	1
2	Add 2004 IDPH license paid in 2002	200	20	2
3	Offset CNA class book reimbursements received	(150)	13	3
4	Offset medical supply rebate	(245)	10	4
5	Offset MDS Coordinator salary reimbursments received	(1,650)	10	5
6	Eliminate expense for 2003 CNA exams paid in 2004	(450)	13	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(4,513)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center **#** 0039347 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(36)	0	0	0	0	0	0	0	0	0	0	(36)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	389	0	0	0	0	0	0	0	0	0	389	5
6	Maintenance	0	432	0	0	0	0	0	0	0	0	0	432	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(36)	821	0	0	0	0	0	0	0	0	0	785	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,895)	0	0	0	0	0	0	0	0	0	0	(1,895)	10
10a	Therapy	0	0	2,617	0	0	0	0	0	0	0	0	2,617	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	(600)	0	0	0	0	0	0	0	0	0	0	(600)	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,495)	0	2,617	0	0	0	0	0	0	0	0	122	16
	C. General Administration													
17	Administrative	0	59,363	(124,149)	0	0	0	0	0	0	0	0	(64,786)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,019	(34,115)	0	0	0	0	0	0	0	0	(33,096)	19
20	Fees, Subscriptions & Promotions	(26,839)	369	0	0	0	0	0	0	0	0	0	(26,470)	20
21	Clerical & General Office Expenses	0	11,797	0	0	0	0	0	0	0	0	0	11,797	21
22	Employee Benefits & Payroll Taxes	0	9,378	0	0	0	0	0	0	0	0	0	9,378	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,306)	8,893	0	0	0	0	0	0	0	0	0	6,587	24
25	Other Admin. Staff Transportation	0	4,551	0	0	0	0	0	0	0	0	0	4,551	25
26	Insurance-Prop.Liab.Malpractice	0	850	0	0	0	0	0	0	0	0	0	850	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(29,145)	96,220	(158,264)	0	0	0	0	0	0	0	0	(91,189)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(31,676)	97,041	(155,647)	0	0	0	0	0	0	0	0	(90,282)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Montgomery Nursing and Rehabilitation Center** **#** **0039347** **Report Period Beginning:** **01/01/2004** **Ending:** **12/31/2004**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	2,715	0	0	0	0	0	0	0	0	0	2,715	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(275)	0	(22,409)	0	0	0	0	0	0	0	0	(22,684)	32
33	Real Estate Taxes	0	443	0	0	0	0	0	0	0	0	0	443	33
34	Rent-Facility & Grounds	0	2,962	0	0	0	0	0	0	0	0	0	2,962	34
35	Rent-Equipment & Vehicles	0	0	603	0	0	0	0	0	0	0	0	603	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(275)	6,120	(21,806)	0	0	0	0	0	0	0	0	(15,961)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(31,951)	103,161	(177,453)	0	0	0	0	0	0	0	0	(106,243)	45

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John H. Rothert	60.00	Jerseyville Nursing and Rehabilitation Ctr, Inc.	Jerseyville, IL	Wellington Mgt Co	Chesterfield, MO	Management Co
David L. Kamler	15.00	Westwood Hills Health Care Center	Poplar Bluff, MO	Health Care Financial	Alton, IL	Management Co
J. Terry Dooling	15.00	Spanish Lake Nursing and Rehabilitation Ctr	Florissant, MO	C.J. Schlosser & Co	Alton, IL	Public Accountants
Jack A. Yaeger	10.00			NW Rehab, L.L.C.	Alton, IL	Therapy Co
				Three Amigos, LLC	Alton, IL	Real Estate Co

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	See Schedule VIII	$	Wellington Management Co	60.00%	$ 389	$ 389	1
2	V	6	See Schedule VIII		Wellington Management Co	60.00%	432	432	2
3	V	17	See Schedule VIII		Wellington Management Co	60.00%	59,363	59,363	3
4	V	19	See Schedule VIII		Wellington Management Co	60.00%	1,019	1,019	4
5	V	20	See Schedule VIII		Wellington Management Co	60.00%	369	369	5
6	V	21	See Schedule VIII		Wellington Management Co	60.00%	11,797	11,797	6
7	V	22	See Schedule VIII		Wellington Management Co	60.00%	9,378	9,378	7
8	V	24	See Schedule VIII		Wellington Management Co	60.00%	8,893	8,893	8
9	V	25	See Schedule VIII		Wellington Management Co	60.00%	4,551	4,551	9
10	V	26	See Schedule VIII		Wellington Management Co	60.00%	850	850	10
11	V	30	See Schedule VIII		Wellington Management Co	60.00%	2,715	2,715	11
12	V	33	See Schedule VIII		Wellington Management Co	60.00%	443	443	12
13	V	34	See Schedule VIII		Wellington Management Co	60.00%	2,962	2,962	13
14	Total			$			$ 103,161	$ * 103,161	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	35	See Schedule VIII	$	Wellington Management Co.	60.00%	$ 603	$ 603	15
16	V	10	Nursing & Medical Records	16,948	Wellington Management Co.	60.00%	16,948		16
17	V	17	Management Fees	118,437	Wellington Management Co.	60.00%		(118,437)	17
18	V	17	Management Fees	46,562	Health Care Financial, L.L.C.	40.00%	40,850	(5,712)	18
19	V	19	Professional Services	34,115	C.J. Schlosser & Company, L.L.C.	40.00%		(34,115)	19
20	V	10a	Therapy Services	210,153	NW Rehab, L.L.C.	100.00%	212,770	2,617	20
21	V	32	Interest		Health Care Financial, L.L.C.	40.00%	2,083	2,083	21
22	V	32	Interest	16,871	John H. Rothert	60.00%		(16,871)	22
23	V	32	Interest	3,810	J. Terry Dooling	15.00%		(3,810)	23
24	V	32	Interest	3,811	David L. Kamler	15.00%		(3,811)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 450,707			$ 273,254	$ * (177,453)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Ce # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	John H. Rothert	President	Administrative	60.00	219,520	6.81	17.00	Salary	$ 45,055	17,8	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 45,055		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Wellington Management Company
Street Address: 750 Spirit 40 Park Drive
City / State / Zip Code: Chesterfield, MO 63005
Phone Number: (636) 537-8447
Fax Number: (636) 537-8446

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Accumulated Costs	16,892,315	5	$ 2,285	$	2,876,615	$ 389	1
2	6	Maintenance	Accumulated Costs	16,892,315	5	2,536		2,876,615	432	2
3	17	Administrative	Accumulated Costs	16,892,315	5	348,599	348,599	2,876,615	59,363	3
4	19	Professional Services	Accumulated Costs	16,892,315	5	5,982		2,876,615	1,019	4
5	20	Dues, Fees, Subs & Promos	Accumulated Costs	16,892,315	5	2,166		2,876,615	369	5
6	21	Clerical and General Office Exp	Accumulated Costs	16,892,315	5	69,278	31,999	2,876,615	11,797	6
7	22	Employee Benefits and PR Taxes	Accumulated Costs	16,892,315	5	55,073		2,876,615	9,378	7
8	24	Travel and Seminar	Accumulated Costs	16,892,315	5	52,224		2,876,615	8,893	8
9	25	Other Admin Staff Transport	Accumulated Costs	16,892,315	5	26,725		2,876,615	4,551	9
10	26	Insurance-Prop., Liab., Malprac.	Accumulated Costs	16,892,315	5	4,990		2,876,615	850	10
11	30	Depreciation	Accumulated Costs	16,892,315	5	15,946		2,876,615	2,715	11
12	33	Real Estate Taxes	Accumulated Costs	16,892,315	5	2,602		2,876,615	443	12
13	34	Rent-Facility & Ground	Accumulated Costs	16,892,315	5	17,395		2,876,615	2,962	13
14	35	Rent-Equipment & Vehicles	Accumulated Costs	16,892,315	5	3,542		2,876,615	603	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 609,343	$ 380,598		$ 103,764	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Cen # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	GMAC Commercial Mortgage		X	Refinance Mortgage	$17,016.17	9/29/99	$ 2,415,500	$ 2,331,947	10/1/34	7.9200	$ 185,502	1
2	Ford Credit		X	Van Loan	$596.16	3/15/04	33,260	28,045	3/14/09	2.9000	746	2
3												3
4								Loan Cost Amortization			4,663	4
5								Interest Income			(275)	5
	Working Capital											
6	Health Care Financial	X		Working Capital	N/A	9/1/97	80,000	80,000	9/1/07	9.5000	2,083	6
7												7
8	First National Bank		X	Line of Credit	N/A	1/4/04	100,000		1/4/05	prime+1%		8
9	TOTAL Facility Related				$17,612.33		$ 2,628,760	$ 2,439,992			$ 192,719	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,628,760	$ 2,439,992			$ 192,719	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 11,711** **Line # 36**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center **#** 0039347 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	32,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	34,207	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,207	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	35,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	37,207	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	28,716	8
	2000	30,459	9
	2001	31,369	10
	2002	31,722	11
	2003	34,207	12

Line 2: 2003 Taxes Paid

Line 4: Accrual is based on 2003 Taxes Paid

Line 7: $37,207 + $443 (Home Office R.E. Tax Allocation) = $37,650 Total R.E. Taxes-Schedule V, Line 33, Col 8

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Montgomery Nursing and Rehabilitation Center COUNTY Montgomery

FACILITY IDPH LICENSE NUMBER 0039347

CONTACT PERSON REGARDING THIS REPORT J. Terry Dooling

TELEPHONE (618) 465-7717 FAX #: (618) 465-7710

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-100-716-75	NE PT SE SW Land Corp Limit	$ 34,206.78	$ 34,206.78
2.		Taylor Springs	$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 34,206.78	$ 34,206.78

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 27,192 B. General Construction Type: Exterior Brick Frame Steel & Brick Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	348,480	1994	$ 27,673	1
2					2
3	TOTALS	348,480		$ 27,673	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	101		1994		$ 962,086	$ 38,483	25	$ 38,483	$	$ 413,697	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Shed			1994	3,247	162	10	162		3,247	9
10	Air Conditioner			1994	76,140	3,807	10	3,807		76,140	10
11	Cabinets			1994	6,809	340	20	340		3,490	11
12	Doors			1994	2,337	117	20	117		1,207	12
13	Electrical			1994	4,601	230	20	230		2,334	13
14	Flooring			1994	25,850	1,749	10	1,749		25,850	14
15	Exterior Remodeling			1994	4,468	298	15	298		3,078	15
16	Interior Remodeling			1994	66,214	4,425	15	4,425		44,974	16
17	Nurse Call System			1994	1,960	131	15	131		1,339	17
18	Plumbing			1994	6,619	331	20	331		3,384	18
19	Roof			1994	29,619	1,730	10	1,730		29,619	19
20	Windows/Gutters			1994	60,254	4,017	15	4,017		41,843	20
21	Siding			1994	15,818	1,055	15	1,055		10,619	21
22	Landscaping			1994	3,134	183	10	183		3,134	22
23	Parking Lot			1994	29,107	1,539	10	1,539		29,107	23
24	Home Office Wallpapering/Flooring			1994	2,692		5			2,692	24
25	Flooring			1995	938	94	10	94		938	25
26	Metal Doors and Frames			1996	953	48	20	48		405	26
27	Metal Carport			1997	972	65	15	65		470	27
28	Carpet			1997	2,310		5			2,310	28
29	Dining Room Chair Rail			1997	2,230	149	15	149		1,041	29
30	Wallpapering			1997	4,830		5			4,830	30
31	Fire Doors			1997	593	30	20	30		208	31
32	Foliage & Fountains			1997	1,657	166	10	166		1,284	32
33	Interior Painting			1997	514		5			514	33
34	Shed			1997	315	31	10	31		223	34
35	Door Alarm System			1997	7,840	784	10	784		5,554	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Sidewalk Replacement	1997	$ 650	$ 43	15	$ 43	$	$ 307	37
38	Beauty Shop Remodeling	1998	4,287	214	20	214		1,340	38
39	Wallpapering	1998	1,493		5			1,493	39
40	Shower Room Remodeling	1998	1,199	60	20	60		380	40
41	Mini Blinds Installed	1998	509	51	10	51		351	41
42	Shelving	1998	566	28	20	28		181	42
43	Baseboard Remodeling	1998	820	82	10	82		567	43
44	Water Heater	1998	6,040	403	15	403		2,517	44
45	Folding Doors	1998	456	46	10	46		285	45
46	Door Installed	1998	208	21	10	21		128	46
47	Wall Mounted Laundry Tub	1998	181	9	20	9		63	47
48	Shower Flooring	1998	401	40	10	40		244	48
49	Shed	1998	185	19	10	19		113	49
50	Flooring	1998	293	29	10	29		188	50
51	Air Conditioning Unit	2000	557	56	10	56		256	51
52	Asphalt Parking Lot	2000	2,360	236	10	236		1,023	52
53	Fire Doors	2001	1,534	102	15	102		366	53
54	Signage	2001	3,318	664	5	664		2,378	54
55	Cove Base	2001	1,006	101	10	101		359	55
56	Window Treatments	2001	7,272	1,454	5	1,454		5,212	56
57	Wallpapering	2001	37,693	7,539	5	7,539		26,966	57
58	Lobby Carpet	2001	1,433	287	5	287		1,051	58
59	Air Conditioner	2001	1,696	170	10	170		594	59
60	Home Office Wallpapering	1999	453		5	15	15	453	60
61	Cove Base	2002	604	60	10	60		131	61
62	Wallpapering	2002	4,462	892	5	892		2,446	62
63	Air Conditioner	2002	1,981	198	10	198		528	63
64	Blinds	2002	512	102	5	102		299	64
65	Flooring & Cove Base	2002	1,630	163	10	163		475	65
66	Wall Guard	2002	1,927	128	15	128		364	66
67	Fire Doors	2002	1,042	69	15	69		174	67
68	A/C / Heat Pump Units	2002	1,580	158	10	158		382	68
69	Home Office Light Fixtures	2002	164		10	16	16	48	69
70	TOTAL (lines 4 thru 69)		$ 1,412,619	$ 73,388		$ 73,419	$ 31	$ 765,193	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,412,619	$ 73,388		$ 73,419	$ 31	$ 765,193	1
2	Air Conditioners	2003	3,110	311	10	311		429	2
3	11 Fire Doors	2003	5,950	397	15	397		496	3
4	Home Office Cabinets	2003	710		10	71	71	107	4
5	Closet Doors-Resident Rooms	2004	3,628	123	15	123		123	5
6	Wiring Outside Lights	2004	1,145	52	20	52		52	6
7	Tile	2004	878	80	10	80		80	7
8	Commercial Water Heater	2004	7,664	383	10	383		383	8
9	Floor Tile	2004	1,186	10	10	10		10	9
10	66 Gallon Water Heater	2004	931	8	10	8		8	10
11	Patio & Sidewalks	2004	14,316	318	15	318		318	11
12	Concrete Dumpster Pad/Fencing	2004	1,520	51	15	51		51	12
13	Gravel Parking Lot	2004	3,355	503	5	503		503	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,457,012	$ 75,624		$ 75,726	$ 102	$ 767,753	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 164,080	$ 17,440	$ 18,141	$ 701	5-20	$ 73,157	71
72	Current Year Purchases	33,188	2,252	2,395	143	5-15	2,395	72
73	Fully Depreciated Assets	300,683	1,768	1,870	102	5-7	300,683	73
74								74
75	TOTALS	$ 497,951	$ 21,460	$ 22,406	$ 946		$ 376,235	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	1997 Minivan	2000-Sold 2004	$	$ 632	$ 632	$	4	$	76
77	Facility Use	2004 Ford Wheelchair Van	2004	35,799	7,458	7,458		4	7,458	77
78	Home Office - Admin	2000 Ford Taurus	2000	4,056		676	676	4	4,056	78
79	See Schedule Attached			6,065		991	991	4	991	79
80	TOTALS			$ 45,920	$ 8,090	$ 9,757	$ 1,667		$ 12,505	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,028,556	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 105,174	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 107,889	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 2,715	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,156,493	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? N/A YES N/A NO

16. Rental Amount for movable equipment: $ 2,176 Description: Ice Machines $2140; Gas Tank $36
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			459		459
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)		4,800		4,800
6	Transportation					
7	Contractual Payments			543		543
8	Nurse Aide Competency Tests			1,250		1,250
9	TOTALS		$	$ 7,052	$	$ 7,052
10	SUM OF line 9, col. 1 and 2	(e)	$ 7,052			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	19
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	21

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,8	2994 hrs	$ 94,305		$	$ 76	2,994	$ 94,381	1
2	Licensed Speech and Language Development Therapist	10a,8	946 hrs	34,653				946	34,653	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,8	2824 hrs	83,812			873	2,824	84,685	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				72,088		72,088	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Laboratory Fees Other (specify): X-Rays	39,3 39,3				5,400 1,681			5,400 1,681	13
14	TOTAL			$ 212,770		$ 7,081	$ 73,037	6,764	$ 292,888	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center **#** 0039347 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 42,632	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 35,755)	626,786		3
4	Supply Inventory (priced at cost)	12,817		4
5	Short-Term Investments			5
6	Prepaid Insurance	33,391		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	10,179		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 725,805	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	30,300		12
13	Land	82,116		13
14	Buildings, at Historical Cost	1,398,550		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	522,126		16
17	Accumulated Depreciation (book methods)	(1,140,207)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	31,850		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan Costs	138,742		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,063,477	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,789,282	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 504,706	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,787		30
31	Accrued Taxes Payable (excluding real estate taxes)	20,108		31
32	Accrued Real Estate Taxes(Sch.IX-B)	35,000		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Payroll Liabilities Payable	263		36
37	Due to Related Parties	310,120		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 938,984	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	220,837		39
40	Mortgage Payable	2,331,947		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,552,784	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,491,768	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,702,486)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,789,282	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,730,657)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,730,657)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	28,171	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 28,171	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,702,486)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,216,056	1
2	Discounts and Allowances for all Levels	(433,106)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,782,950	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	432,242	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 432,242	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	5,091	11
12	Gift and Coffee Shop	1,192	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	36	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	66,979	19
20	Radiology and X-Ray	59	20
21	Other Medical Services		21
22	Laundry	60	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 73,417	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	275	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 275	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	6,728	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,728	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,295,612	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	657,032	31
32	Health Care	1,386,456	32
33	General Administration	716,346	33
	B. Capital Expense		
34	Ownership	371,671	34
	C. Ancillary Expense		
35	Special Cost Centers	80,486	35
36	Provider Participation Fee	55,450	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,267,441	40
41	**Income before Income Taxes (line 30 minus line 40)****	28,171	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 28,171	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not yet filed **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,123	2,123	$ 49,267	$ 23.21	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,642	8,774	160,210	18.26	3
4	Licensed Practical Nurses	14,114	15,073	225,530	14.96	4
5	Nurse Aides & Orderlies	61,415	65,222	535,692	8.21	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,766	5,019	45,806	9.13	10
11	Social Service Workers	1,846	2,095	28,255	13.49	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	20,415	21,661	160,298	7.40	15
16	Dishwashers					16
17	Maintenance Workers	4,097	4,243	43,785	10.32	17
18	Housekeepers	10,504	11,441	82,638	7.22	18
19	Laundry	8,881	9,537	55,332	5.80	19
20	Administrator	2,080	2,080	58,975	28.35	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,925	4,347	57,404	13.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,242	2,428	30,267	12.47	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	145,050	154,043	$ 1,533,459 *	$ 9.95	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	117	$ 5,595	1,3	35
36	Medical Director	N/A	9,600	9,3	36
37	Medical Records Consultant	16	776	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	N/A	1,276	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	8	559	11,3	44
45	Social Service Consultant	10	726	12,3	45
46	Other(specify) Advisory Board	N/A	200	10,3	46
47	Quality Assurance Nurse	N/A	16,948	10,3	47
48					48
49	TOTAL (lines 35 - 48)	151	$ 35,680		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ Section N/A		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45. ** See instructions.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carla Vonder Haar	Administrator	0.00	$ 58,975
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 58,975

B. Administrative - Other

Description	Amount
Wellington Management Company - Management Fees	$ 118,437
Health Care Financial, L.L.C. - Management Fees	46,562
TOTAL (agree to Schedule V, line 17, col. 3)	$ 164,999
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company, L.L.C.	Accounting Services	$ 34,115
Hughes & Associates, CPA	Audit Fees	5,689
Ted Frapolli	Legal Services	209
Duane Morris	Legal Services	978
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 40,991

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 51,221
Unemployment Compensation Insurance	29,843
FICA Taxes	116,369
Employee Health Insurance	25,538
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Staff Relations	4,123
Employee Disability Insurance	288
Employee Dental Insurance	1,230
Home Office Employee Benefits	9,378
TOTAL (agree to Schedule V, line 22, col.8)	$ 237,990

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	10,931
Health Care Worker Background Check	
(Indicate # of checks performed 89)	1,196
Dues, Subscriptions & Manuals	1,675
Licenses & Fees	523
Bank Service Charge	2,369
IHCA Dues	3,721
Home Office Dues, Fees & Subscriptions	369
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,984

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,448
Seminar Expense	2,008
Home Office Travel & Seminar	8,893
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,349

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	Schedule Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Montgomery Nursing and Rehabilitation Center # 0039347 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $3,721**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,392** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **55,450**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **36**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **17.4%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **None**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Hughes & Associates** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

MONTGOMERY NURSING & REHABILITATION CENTER, INC.
RECLASSES
ATTACHMENT TO SCHEDULE V
12/31/04

DESCRIPTION	LINE #	INCREASE (DECREASE)
DUES, FEES, SUBSCRIPTIONS AND PROMOTIONS	20	(2,109)
NURSE AIDE TRAINING	13	2,109
To reclass expenses for CNA class books & test fees to proper line		
ADMINISTRATIVE	17	(760)
MAINTENANCE	6	410
NURSING & MEDICAL RECORDS	10	202
EMPLOYEE BENEFITS & PAYROLL TAXES	22	148
To reclass maintenance supplies, dental visits & employee medical to proper lines		
NURSE AIDE TRAINING	13	438
NURSING & MEDICAL RECORDS	10	(438)
To reclass CNA class evaluator to proper line		
NURSE AIDE TRAINING	13	4,800
NURSING & MEDICAL RECORDS	10	(4,800)
To reclass CNA trainer wages		
NURSE AIDE TRAINING	13	305
TRAVEL & SEMINAR	24	(305)
To reclass expenses for CNA class books & test fees to proper line		

MONTGOMERY NURSING & REHABILITATION CENTER, INC.
MISCELLANEOUS INCOME
ATTACHMENT TO SCHEDULE XVII, PAGE 19, LINE 28
12/31/04

CNA Books Purchased	150
Reimbursment of MDS Coordinator's Salary for Training Done at Other Home	1,650
Seniorcise Program Income	1,200
Gain on Sale of Old Van	1,939
Med Supply Rebate	245
Copies	50
Other Miscellaneous Income	1,494
	6,728

MONTGOMERY NURSING & REHABILITATION CENTER, INC.
TRAVEL AND SEMINAR SCHEDULE
ATTACHMENT TO SCHEDULE XIX PART G
12/31/2004

SEMINAR PARTICIPANT	JOB TITLE	DATE(S)	CITY	TITLE OF SEMINAR	SPONSOR	COST	SEMINAR LODGING/ TRAVEL/MEALS
Mindy Pearse	MDS Coordinator	8/11/2004	Springfield, IL	Illinois Medicaid Reimbursement	IHCA	90	
Birdie Scroggins & Ginny Turner	Activities	10/21-10/22/04	Decatur, IL	2004 IAPA Conference	IAPA	350	327
Various	Various	1/2004	Hillsboro, IL	CPR Class & Certifications	Holly Harvey, Instructor & Montgomery Co. CPR Assoc.	224	
Candy Jones	CNA	5/19-5/21/04	Springfield, IL	Occup Rehab Aide Training Program	Lincoln Land Community College	200	
Carla Vonderhaar	Administrator	2/27, 3/12&26, 4/9,23,30	Collinsville, IL	Multi-Disciplinary Certificate Program in Geriatrics for Non-physicians	Univ. of Illinois, Dept. of Family Medicine	395	
Various	Various	9/2004	Springfield, IL	2004 IHCA Convention	IHCA	297	124
						1,556	452
					Total Seminar Lodging/Travel/Meals	452	
					Other Travel Expense <$250	2,448	
					Home Office Travel & Seminar	8,893	
					Total Travel & Seminar, Line 24	13,349	

Montgomery Nursing & Rehabilitation Center
Attachment to Sch. XI, Part D
December 31, 2004

Detail of Line 79: Home Office Admin Vehicles

Model, Make & Year	Year Acquired	Cost	Current Book Depreciation	Straight Line Depreciation	Adjustments	Life in Years	Accumulated Depreciation
1998 Jaguar	2004	3,827	0	478	478	4	478
2001 Infiniti	2004	2,238	0	513	513	4	513
		6,065	0	991	991		991